

DISABILITIES SERVICES

SECTION 2: AGENCY AUDIT, BUDGET and FISCAL ITEMS

INSTRUCTIONS and FORMS

ITEMS:

17. Taxation Status
18. Certified Audit/Board Approved Financial Statement
19. Accounting Policies and Procedure Manual
20. Indirect Cost Allocation Plan (Forms 6, 6A, and 6D through 6H)
21. Agency Billing Procedure
22. Agency Employee Hours and Salaries (Forms 2 and 2A), Employee Demographics Summary (Form 2B) and Employee Hours Related Organization Disclosure (Form 2C)
23. Total Agency Anticipated Expenses and Revenue (Forms 5 and 5A)

SECTION 2: AGENCY AUDIT, BUDGET and FISCAL ITEMS

17. Taxation Status

State whether your agency is for profit or not-for-profit. For not-for-profit agencies, indicate federal/state tax status. If tax exempt, include copies of federal/state documentation such as a copy of the letter granting exempt status.

18. Certified Public Accountant (CPA) Audit Report or Board Approved Financial Statement.

a. Agencies under contract with the DHHS are required to submit to the County, two (2) original copies of a certified audit report in compliance with the "AUDIT REQUIREMENTS," as specified in the Purchase of Service Contract. The audit report shall be performed by an independent certified public accountant (CPA) licensed to practice by the State of Wisconsin. The CPA audit report shall include:

- (1) financial statements;
- (2) auditor's reports, and required schedules;
- (3) statement of revenues identified by funding source for each program, and functional expenses and variances from budget for each program identified on the EXHIBIT I of the Purchase of Service Contract;
- (4) statement of revenues and expenses by program, agency-wide.

Please see Section 4 for the required format of program revenue and expense schedules. Omission of these required schedules or deviations from the required formats and classifications in these schedules, may result in disallowance of otherwise allowable costs and recovery of those disallowed costs by DHHS from the Contractor.

Organizations exempt from income tax under Section 501(c) of the Internal Revenue Code are required to submit a copy of their Internal Revenue Service (IRS) Form 990 with their corresponding CPA audit report.

The Milwaukee County Department of Health and Human Services Administrative Probation Policy for Non-Compliance with Contract and Fee-for-Service Requirements is incorporated as part of the Contract.

A copy of the DHHS *Administrative Probation Policy for Non-Compliance with Contract and Fee-for-Service Requirements* may be obtained from DHHS Contract Administration, Phone: (414) 289-5954.

The certified audit report for contractors currently (2005) under contract with the DHHS reporting on a calendar year fiscal period is due **June 30, 2006**, or such later date that is mutually agreed to by County and Contractor. Certified audit reports for the Year 2006 contractors reporting on a calendar year fiscal period are due **June 30, 2007**.

The certified audit report for contractors currently (2005) under contract with the DHHS **reporting on a fiscal period other than a calendar year** is due within 180 calendar days of the fiscal year closing, or such later date that is mutually agreed to by County and Contractor. Certified audit reports for the Year 2006 contractors **reporting on a fiscal period other than a calendar year** are due within 180 calendar days of the fiscal year closing.

- b. **Agencies not under contract with the DHHS** should submit a copy of the agency's prior year certified audit or the most recent Board of Directors approved financial statement if an audit has not been performed for that year.

19. Accounting Policies and Procedures Manual

Submit a copy of the agency's accounting policies and procedures manual. The manual must comply with General Accepted Accounting Principles (GAAP) and the Wisconsin Department of Health and Family Services (DHFS) allowable cost policies. A copy of the DHFS Allowable Cost Policy Manual may be obtained from DHHS Contract Administration, Phone: (414) 289-5954 or online at:

<http://county.milwaukee.org/display/router.asp?docid=9853>. The DHFS allowable cost policy cannot be submitted in lieu of the agency's own manual.

20. Indirect Cost Allocation Plan (Forms 6, 6A and 6D through 6H)

All agencies and organizations which are awarded a Purchase of Service Contract with the DHHS are required to submit an Indirect Cost Allocation Plan for review and approval under the following conditions:

- a. the agency provides more than one program or service for Milwaukee County;
- b. the agency provides one program or service for Milwaukee County and one or more other purchasers or funding sources and/or one or more other functions such as fundraising during the same period;
- c. the agency allocates costs for general and administrative expenses between itself and an affiliated agency or entity.

As part of the Indirect Cost Plan, describe the formula and/or the method used to allocate indirect costs to each program or service under contract.

Contracts cannot be executed unless an Indirect Cost Allocation Plan is on file with the DHHS.

Indirect costs must be allocated in a manner consistent with the instructions in the Federal Office of Management and Budget (OMB) *Circular A-122: Cost Principles for State and Local Governments* and the State DHFS *Allowable Cost Policy Manual*. Copies of these documents may be obtained from DHHS, Contract Administration, Phone: (414) 289-5954 or online from DHFS at www.dhfs.state.wi.us/grants/index.htm. The Indirect Cost Allocation Plan Forms can be found on pages 53 - 58.

21. Agency Billing Procedure

Agencies applying to DHHS for funding must submit a copy of the agency's billing policies and procedures including procedures for collecting financial information, determining liability, the basis of billing activities, and payment provisions. Describe billing procedures for both clients and third-party payment sources. The policies must be consistent with Wisconsin Administrative Code HSS 1, Uniform Fee System. HSS 1 should be used as a guide and cannot be submitted in lieu of an agency procedure.

Agencies providing services to Delinquency and Court Services clients may not bill for services unless authorized by staff.

22. Agency Employee Hours and Salaries and Employee Demographics Summary

Report the (1) *Position Titles*; (2) *Codes (Salary Description)*; (3) *Gender and Ethnic/Racial Group*; (4) *Hours/Week-Yearly Salary*; and, (5-9) *allocation of salaries for specific programs* of each employee position, including **executive positions**, that have any portion of their time directly allocated to a Disabilities Services, Delinquency and Court Services and/or Economic Support programs on Forms 2 and 2A. **Instructions for completing Forms 2 and 2A are on pages 59 - 60.** Forms 2 and 2A can be found on pages 61 - 62.

Report employee demographics on Form 2B. Instructions for completing Form 2B are on pages 63 - 65. *Employee Demographics Summary Form* (Sample Page) is on page 64.

Report the hours of employees who work for more than one related organization on the form *Employee Hours - Related Organization Disclosure* included in this section on page 66.

23. Total Agency Expenses and Revenues

Report the **total** agency's actual contract year anticipated expenses and revenues on Forms 5/5A. When completing these forms refer to the expense and revenue control accounts included in the last section of these guidelines. **Forms 5 and 5A are on pages 70 - 71.** Form 5S, which is not a mandatory submittal, is on pages 72-76.

Recommended Order for Preparing Indirect Cost Allocation Plan

Form 5. Prepare Form 5, leaving “*Control Account 9200*” blank, using an individual column E for each DHHS program you are applying for.

Form 6. Prepare Form 6 from the amounts reported in Form 5, col. F. Assign the individual costs in column C to the individual cost pools in columns D through H.

Forms 6D through 6H. Prepare the cost pool allocations from the related columns D through H on Form 6. Allocate indirect costs to the individual DHHS programs applied for based on the total allocation basis of the individual programs relative to that of the Agency as a whole.

Form 3 – Control Account 9200. Prepare an individual Form 3 for each DHHS program you are applying for, regardless of which Division. For each program applied for, insert the total allocated costs from Forms 6D through 6H.

Form 5. Transfer the total allocated cost (Control Account 9200) from each of the Form(s) 3 to Form 5.

FORMS 6 and 6D through 6H – INSTRUCTIONS **INDIRECT COST ALLOCATION PLAN**

FORM 6 Summary Sheet

Column C - **Bring forward the total agency indirect costs for each Control Account from Form 5, Column F.**

Column D
Through

Column H **Assign the anticipated expenses from Column C to the cost pool(s) determined by the basis on which those indirect costs shall be allocated.**

FORMS 6D through 6H Cost Pool Allocation

Column C - **Bring forward the total cost pool expenses for each Control Account from the related Form 6, Columns D through H.**

TOTAL
INDIRECT

COSTS - **Allocate the total agency indirect costs to the individual programs in columns D through L on the basis of the ratio of the allocation basis for the individual program to the allocation basis agency-wide.**

Form 6 **YEAR 2006 INDIRECT COST ALLOCATION PLAN**
Summary Sheet

1 Agency Name: _____

2 Disability/Target Group: _____

(Use additional copies of this form as needed.)

A	B	C	Form 6D	Form 6E	Form 6F	Form 6G	Form 6H	I
Account Number	Indirect Cost Account Description	Total Agency Indirect Costs Σ col (D) to col (H)	Direct Salaries Allocation	FTE Allocation	Square Footage Allocation	Direct Cost Allocation	Other Allocation Basis	Unallowable Indirect Costs**
7000	Salaries							
7100	Employee Health & Retirement Ben.							
7200	Payroll Taxes							
8000	Professional Fees							
8100	Supplies							
8200	Telephone							
8300	Postage & Shipping							
8400	Occupancy							
8500	Rental & Maintenance of Equip.							
8600	Printing & Publications							
8700	Employee Travel							
8800	Conferences, Conventions, Meetings							
8900	Specific Assistance to Individuals							
9000	Membership Dues							
9100	Awards & Grants							
9600	Allocations to Agencies							
-----	Interest							
-----	Bad Debt							
-----	Other Miscellaneous (Specify)							
	TOTAL INDIRECT COSTS *							

* Individual line entries for Total Agency Indirect Costs (column C) should be entered on the corresponding respective line on Form 5, column F.

** Enter Agency Indirect Costs which may not be allocated to Milwaukee County Programs under Federal & State Cost Principles

As part of program budgeting, agencies which are contracted to provide more than one program are required to assign indirect costs to each program under contract. Describe the formula/method used to distribute indirect costs to programs.

Date Submitted: _____

Indirect Cost Allocation Plan

Item # 20

Form 6D

YEAR 2006 INDIRECT COST ALLOCATION PLAN Allocation Basis: Direct Salaries

1 Agency Name: _____

2 Disability/Target Group: _____

(Use additional copies of this form as needed.)

A	B	C	D	E	F	G	H	I	J	K	L
Account Number	Indirect Cost Account Description	Allowable Total Direct Salaries Allocation *	(program)	(program)	(program)	(program)	(program)	(program)	(program)	(program)	Other Contracts Programs & Functions
7000	Salaries										
7100	Employee Health & Retirement Ben.										
7200	Payroll Taxes										
8000	Professional Fees										
8100	Supplies										
8200	Telephone										
8300	Postage & Shipping										
8400	Occupancy										
8500	Rental & Maintenance of Equip.										
8600	Printing & Publications										
8700	Employee Travel										
8800	Conferences, Conventions, Meetings										
8900	Specific Assistance to Individuals										
9000	Membership Dues										
9100	Awards & Grants										
9600	Allocations to Agencies										
*****	Interest										
*****	Other Miscellaneous (Specify)										
	TOTAL INDIRECT COSTS **										
	TOTAL DIRECT SALARIES										

* Individual line entries for Total Direct Salaries Allocation (column C) come from the Indirect Cost Summary Form 6 (column D).

** Totals for each Program (columns D through K) should be entered in Control Account Number 9200, Allocated Costs on Form 3 (column C) for each Milwaukee County program
All other non-Milwaukee County contracts, programs & functions should be entered in column L, Total Indirect Costs, and carried to Form 5, column G.

As part of program budgeting, agencies which are contracted to provide more than one program are required to assign indirect costs to each program under contract. Describe the formula/method used to distribute indirect costs to programs.

Date Submitted: _____

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Indirect Cost Allocation Plan

Item # 20

Form 6E YEAR 2006 INDIRECT COST ALLOCATION PLAN Allocation Basis: Direct FTE

1 Agency Name: _____

2 Disability/Target Group: _____

(Use additional copies of this form as needed.)

A	B	C	D	E	F	G	H	I	J	K	L
Account Number	Indirect Cost Account Description	Allowable Total Direct FTE Allocation *	(program)	(program)	(program)	(program)	(program)	(program)	(program)	(program)	Other Contracts Programs & Functions
7000	Salaries										
7100	Employee Health & Retirement Ben.										
7200	Payroll Taxes										
8000	Professional Fees										
8100	Supplies										
8200	Telephone										
8300	Postage & Shipping										
8400	Occupancy										
8500	Rental & Maintenance of Equip.										
8600	Printing & Publications										
8700	Employee Travel										
8800	Conferences, Conventions, Meetings										
8900	Specific Assistance to Individuals										
9000	Membership Dues										
9100	Awards & Grants										
9600	Allocations to Agencies										
	Interest										
	Other Miscellaneous (Specify)										
	TOTAL INDIRECT COSTS **										
	TOTAL FTE										

* Individual line entries for Total Direct FTE Allocation (column C) come from the Indirect Cost Summary Form 6 (column E).

** Totals for each Program (columns D through K) should be entered in Control Account Number 9200, Allocated Costs on Form 3 (column C) for each Milwaukee County program. All other non-Milwaukee County contracts, programs & functions should be entered in column L, Total Indirect Costs, and carried to Form 5, column G.

As part of program budgeting, agencies which are contracted to provide more than one program are required to assign indirect costs to each program under contract. Describe the formula/method used to distribute indirect costs to programs.

Date Submitted: _____

Rev 6/05

Indirect Cost Allocation Plan

Item # 20

Form 6F YEAR 2006 INDIRECT COST ALLOCATION PLAN Allocation Basis: Square Footage

1 Agency Name: _____

2 Disability/Target Group: _____

(Use additional copies of this form as needed.)

A Account Number	B Indirect Cost Account Description	C Allowable Total Direct Sq Footage Allocation *	D (program)	E (program)	F (program)	G (program)	H (program)	I (program)	J (program)	K (program)	L Other Contracts Programs & Functions
7000	Salaries										
7100	Employee Health & Retirement Ben.										
7200	Payroll Taxes										
8000	Professional Fees										
8100	Supplies										
8200	Telephone										
8300	Postage & Shipping										
8400	Occupancy										
8500	Rental & Maintenance of Equip.										
8600	Printing & Publications										
8700	Employee Travel										
8800	Conferences, Conventions, Meetings										
8900	Specific Assistance to Individuals										
9000	Membership Dues										
9100	Awards & Grants										
9600	Allocations to Agencies										
	Interest										
	Other Miscellaneous (Specify)										
	TOTAL INDIRECT COSTS **										
	TOTAL SQUARE FOOTAGE										

* Individual line entries for Total Direct Square Footage Allocation (column C) come from the Indirect Cost Summary Form 6 (column F).

** Totals for each Program (columns D through K) should be entered in Control Account Number 9200, Allocated Costs on Form 3 (column C) for each Milwaukee County program
All other non-Milwaukee County contracts, programs & functions should be entered in column L, Total Indirect Costs, and carried to Form 5, column G.

As part of program budgeting, agencies which are contracted to provide more than one program are required to assign indirect costs to each program under contract. Describe the formula/method used to distribute indirect costs to programs.

Date Submitted: _____

Indirect Cost Allocation Plan

Item # 20

Form 6G

YEAR 2006 INDIRECT COST ALLOCATION PLAN

Allocation Basis: Direct Cost

1 Agency Name: _____

2 Disability/Target Group: _____

(Use additional copies of this form as needed.)

A	B	C	D	E	F	G	H	I	J	K	L
Account Number	Indirect Cost Account Description	Allowable Total Direct Cost Allocation *	(program)	(program)	(program)	(program)	(program)	(program)	(program)	(program)	Other Contracts Programs & Functions
7000	Salaries										
7100	Employee Health & Retirement Ben.										
7200	Payroll Taxes										
8000	Professional Fees										
8100	Supplies										
8200	Telephone										
8300	Postage & Shipping										
8400	Occupancy										
8500	Rental & Maintenance of Equip.										
8600	Printing & Publications										
8700	Employee Travel										
8800	Conferences, Conventions, Meetings										
8900	Specific Assistance to Individuals										
9000	Membership Dues										
9100	Awards & Grants										
9600	Allocations to Agencies										
	Interest										
	Other Miscellaneous (Specify)										
	TOTAL INDIRECT COSTS **										
	TOTAL DIRECT COSTS										

* Individual line entries for Total Direct Cost Allocation (column C) come from the Indirect Cost Summary Form 6 (column G).

** Totals for each Program (columns D through K) should be entered in Control Account Number 9200, Allocated Costs on Form 3 (column C) for each Milwaukee County program. All other non-Milwaukee County contracts, programs & functions should be entered in column L, Total Indirect Costs, and carried to Form 5, column G.

As part of program budgeting, agencies which are contracted to provide more than one program are required to assign indirect costs to each program under contract. Describe the formula/method used to distribute indirect costs to programs.

Date Submitted: _____

Rev 6/05

Indirect Cost Allocation Plan

Item # 20

Form 6H

YEAR 2006 INDIRECT COST ALLOCATION PLAN

Allocation Basis: Other Allocation Basis

1. Agency Name: _____

2. Disability/Target Group: _____

(Use additional copies of this form as needed.)

A	B	C	D	E	F	G	H	I	J	K	L
Account Number	Indirect Cost Account Description	Total Other Allowable Allocation Basis *	(program)	(program)	(program)	(program)	(program)	(program)	(program)	(program)	Other Contracts Programs & Functions
7000	Salaries										
7100	Employee Health & Retirement Ben.										
7200	Payroll Taxes										
8000	Professional Fees										
8100	Supplies										
8200	Telephone										
8300	Postage & Shipping										
8400	Occupancy										
8500	Rental & Maintenance of Equip.										
8600	Printing & Publications										
8700	Employee Travel										
8800	Conferences, Conventions, Meetings										
8900	Specific Assistance to Individuals										
9000	Membership Dues										
9100	Awards & Grants										
9600	Allocations to Agencies										
	Interest										
	Other Miscellaneous (Specify)										
	TOTAL INDIRECT COSTS *										
	TOTAL ALLOCATION BASIS										

* Individual line entries for Total Other Allocation Basis (column C) come from the Indirect Cost Summary Form 6 (column H).

** Totals for each Program (columns D through K) should be entered in Control Account Number 9200, Allocated Costs on Form 3 (column C) for each Milwaukee County program. All other non-Milwaukee County contracts, programs & functions should be entered in column L, Total Indirect Costs, and carried to Form 5, column G.

As part of program budgeting, agencies which are contracted to provide more than one program are required to assign indirect costs to each program under contract. Describe the formula/method used to distribute indirect costs to programs.

Date Submitted: _____

Rev 6/05

FORMS 2 and 2A INSTRUCTIONS

AGENCY EMPLOYEE HOURS and SALARIES

Use Form 2A only, if an agency has fourteen (14) or fewer employees. For agencies with more than fourteen (14) employees, use multiple copies of Form 2 with Form 2A as the final page.

Column 1 - Position Title

Enter the title of each position that has any portion of its time directly allocated to a Disabilities Services, Delinquency and Court Services, and/or Economic Support programs.

Do not include information for Control Account Number 9200, Administrative Costs (Indirect Costs). If a position is vacant, list the title of the position and "vacant" under it.

Column 2 - Code

In column 2, check Form 3S, Control Account No. 7000 and use the same number as the last digit of the Sub-Account Number which corresponds to the Account Description of salaries.

For example: 1 for Executive Salaries; 2 for Professional Salaries; 3 for Clerical Staff; 4 for Technical Salaries and so forth. If an employee is included in more than one sub-account, use the primary sub-account number.

Column 3 - Ethnic/Race and Gender Codes

In column 3 enter the code representing the race or ethnicity of the employee.

Ethnic/Race Codes:

A: Asian or Pacific Islander
B: Black
H: Hispanic
I: American Indian
W: White

Gender Codes:

F: Female
M: Male

These classifications are uniform throughout the State Department of Health and Family Services and have been negotiated between the DHHS Affirmative Action/Civil Rights Compliance Office and the various Federal Offices of Civil Rights.

Value Definitions are:

Asian or Pacific Islander: All persons having origins in any of the original peoples of the Far East, Southeast Asian, the Indian subcontinent, or the Pacific Islands. This includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

Black: All persons having origins in any of the Black racial groups of Africa.

FORM 2 and 2A INSTRUCTIONS (continued)

AGENCY EMPLOYEE HOURS and SALARIES

Hispanic: All persons of Mexican, Puerto Rican, Cuban, Central or South America or other Spanish culture or origin, regardless of race. (Excludes Portugal, Spain, or other European countries.)

American Indian or Alaskan Native: All persons having origins in any of the original peoples of North America and who maintain cultural identification through tribal association or community recognition.

White: All persons who are not Asian or Pacific Islander, Black, Hispanic, or American Indian or Alaskan Native.

Enter the letter "h" next to the ethnic code for any handicapped employee.

A "handicapped individual" is defined pursuant to section 504 of the Rehabilitation Act of 1973 as any persons who:

1. Has a physical or mental impairment that substantially limits one or more major life activities (e.g. caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working);
2. Has a record of such impairment, or;
3. Is regarded as having such an impairment.

Column 4 - Hours Per Week - Annual Salary

Enter number of hours worked per week, and the annual salary.

Columns 5 through 9

Salaries must be allocated by specific Disabilities Services, Delinquency and Court Services, and/or Economic Support programs, and by each disability/target group population, and by hours per week and yearly dollar amounts.

After all salaries are listed on Forms 2 and 2A, subtotal each column on Form 2/2A and calculate the percentage of fringe benefits and add to the subtotal. The column subtotals are carried forward to Form 3, 7000 salaries and 7100 Employee Health and Retirement Benefits, and Form 3S by Sub-Account, using Column 2 to determine the Sub-Account breakdown. If you have more programs than will fit on a page, use a separate sheet for each disability/target group.

Item # 22

Agency Name: _____

Date Submitted:

Revised 6/05

Item # 22

Agency Name:

Date Submitted:

Revised 6/05

FORM 2B INSTRUCTIONS

EMPLOYEE DEMOGRAPHICS SUMMARY

Complete for each program within each disability/target group as listed in Columns (5)-(9) of Form 2. For each program, summarize by position code, as listed in Column 2 of Form 2, the number of full-time equivalent employees in every demographic code combination listed in Column 3, Form 2.

Note: The number of full-time equivalent employees is calculated by adding the number of hours per week worked by every employee in each demography code combination and dividing that total by 40 (unless full-time work week is defined by something other than 40 hours/week; if so, specify at the bottom of Form 2B and divide by that number when calculating FTE's).

FORM 2B - EXAMPLES

Two Code 2 positions (Social Workers), who are Black ("B", Col. 3, Form 2) work a total of 60 hours per week in the Adult Day Care Program (Col. 5, Form 2.) To find the FTE, divide the total number of hours worked per week in the Adult Day Care Program by 40, the number of hours a FTE is required to work, i.e., $60/40=1.50$ FTE.

One Code 2 position (Social Worker), who is White ("W", Col. 3, Form 2) works a total of 10 hours per week in the Adult Day Care Program (Col. 5, Form 2.) To find the FTE, divide the total number of hours worked per week in the Adult Day Care Program by 40, the number of hours a FTE is required to work, i.e., $10/40=.25$.

One Code 3 position (Clerical), who is White ("W", Col. 3, Form 2) works a total of 20 hours per week in the Adult Day Care Program (Col. 5, Form 2.) To find the FTE, divide the total number of hours worked per week in the Adult Day Care Program by 40, the number of hours a FTE is required to work, i.e., $20/40=.50$.

One Code 5 position (Maintenance), who is White ("W", Col. 3, Form 2) works a total of 20 hours per week in the Adult Day Care Program (Col. 5, Form 2.) To find the FTE, divide the total number of hours worked per week in the Adult Day Care Program by 40, the number of hours a FTE is required to work, i.e., $20/40=.50$.

SAMPLE PAGE

FORM 2B - YEAR 2006 EMPLOYEE DEMOGRAPHICS SUMMARY **Item # 22**

AGENCY: (Name of Agency)_____

Calculation to determine the number of full-time equivalents (FTE's) assigned to provide the service:

1. Determine the number of hours a full-time employee is required to work per week. This number, usually 40, becomes the denominator. *
2. For each program, Form 2/2A, Columns 5-9, summarize by position code, Form 2/2A, Column 2, and Employee Demographic Code, Form 2/2A, Column 3, the total number of hours worked by position code and employee demographic code. This number becomes the numerator.
3. Divide the total number of hours worked per position code and employee demographic code by the number of hours a full-time employee is required to work to arrive at the number of FTE's (by position code and employee demographic code) working in a program.

Disability/ Target Group	Program	Position Code # (Col.2, Form 2) Code	Employee Demographics	No. of FTE's
		2	B	1.50
		1	W	0.25
		1	H	1.00

*If full-time equivalents (FTE's) are not based on 40 hours per week, specify:
_____hours/week.

Rev 6/05

Date Submitted:_____

FORM 2B - YEAR 2006 EMPLOYEE DEMOGRAPHICS SUMMARY Item # 22**AGENCY:** _____

Calculation to determine the number of full-time equivalents (FTE's) assigned to provide the service:

1. Determine the number of hours a full-time employee is required to work per week. This number, usually 40, becomes the denominator. *
2. For each program, Form 2/2A, Columns 5-9, summarize by position code, Form 2/2A, Column 2, and Employee Demographic Code, Form 2/2A, Column 3, the total number of hours worked by position code and employee demographic code. This number becomes the numerator.
3. Divide the total number of hours worked per position code and employee demographic code by the number of hours a full-time employee is required to work to arrive at the number of FTE's (by position code and employee demographic code) working in a program.

Disability/ Target Group	Program	Position Code # (Col.2, Form 2) Code	Employee Demographics	No. of FTE's

*If full-time equivalents (FTE's) are not based on 40 hours per week, specify:
_____hours/week.

YEAR 2006 EMPLOYEE HOURS - RELATED ORGANIZATION DISCLOSURE

For each employee of your agency who works for more than one related organization which may or may not be under contract to Milwaukee County, the total number of weekly hours scheduled for each affiliated corporate or business enterprise must be accounted for by program/activity. If no employee is so utilized, indicate the non-applicability of this requirement on this form.

The format for reporting employee hours is to be shown in the following example:

<u>Employee Name</u>	<u>Employer</u>	<u>Program/Activity</u>	<u>Total Weekly Hours</u>
Henry Jones	1. ABC Corp. (Parent)	Counseling	8
	2. M&M Assoc. (Subsidiary)	a. Transportation	2
		b. Training	6
	3. XYZ Corp. (Affiliate)	a. Food Service	2
		b. Pharmaceuticals	6
	4. Milwaukee Clinic (Indep)	a. Consulting	8
		b. Workshop	4
		c. Day Care	4
	Total		40
<u>Employee Name</u>	<u>Employer</u>	<u>Program/Activity</u>	<u>Total Weekly Hours</u>

Agency: _____

Date Submitted: _____

FORMS 5 and 5A INSTRUCTIONS

- Column A - See detailed chart of accounts in Section 4 of these guidelines for account definitions.
- Column B - Fill in the 2004 Actual Expenses of the entire Agency by Control Account
- Column C - Fill in the 2005 Gross Budget, or Actual Expenses if available, of the entire Agency by Control Account as adopted by the agency's Board of Directors or owners of the agency.
- Column D - Enter the total 2006 projected annual cost of the entire Agency by Control Account as approved by the agency's Board of Directors or owners of the agency. Column D must equal the sum of the entries in Columns E through G.
- Column(s) E - Enter the 2006 projected annual cost of each individual program applied for by Control Account. Include a separate Column E for each program applied for in Disabilities Services Division, Economic Support Division and Delinquency and Court Services Division. These entries must agree to the amounts reported in each individual Form 3. If the Agency is applying for more than four (4) programs, use additional copies of Form 5 to report **all** programs applied for in **all** DHHS Divisions **individually**.
- Column F - Enter the 2006 projected annual indirect cost to be allocated to programs utilizing a cost allocation plan by Control Account.
- Column G - Enter the 2006 projected annual cost for other functions of the Agency, including fundraising, contracts with other governmental and non-governmental entities, and unallowable costs.

FORM 5 – TOTAL AGENCY ANTICIPATED EXPENSES

Control Accounts - See the Master Chart of Accounts in Section 4 for a detailed listing of the accounts and account descriptions of costs included in each of the Control Accounts.

Control Acct 9200 –

Column(s) E. Bring Forward the summation of allocated indirect cost for each program, for all cost pools, calculated on Forms 6D through 6H.

Column F. Report the total indirect costs allocated to all programs and functions agency-wide as a negative amount.

Column G. Report the total indirect costs allocated the programs and functions other than those reported in Column(s) E.

Column D. Sum the total allocated indirect costs from Columns E, F and G.

Profit Factor –

Non-profit Agencies are not allowed a profit, or to budget for a Reserve, and this line will equal \$-0-.

For Profit entities are allowed under Wisconsin statutes and Administrative Code to retain a profit not to exceed statutory limits. Allowable profit can be calculated on the last page of Form 5S. If the proposed budget will include allowable profit the calculation on the last page of Form 5S **MUST** be included with the budget submission. Bring the total allowable profit from this calculation forward to this line.

Non-DHHS

Revenue - Bring forward the “Total Non-DHHS Contract Revenue” for each column from Form 5A.

FORM 5A – TOTAL AGENCY ANTICIPATED REVENUE

Column E - Include all program related revenue in the appropriate program column. Any revenue specifically for providing the services under one of the DHHS programs applied for is program related revenue and is to be reported as revenue in the appropriate program Column E. If the expenses reported for any DHHS program applied for include services to other purchasers, such as Milwaukee County Department on Aging, other Counties, Municipalities, or other Provider Agencies, the revenues for those services is to be included in the appropriate program Column E.

DHHS CONTRACT

REQUEST - Bring forward the “Total DHHS Request” from Form 5 for each column.

FORM 5S – ANTICIPATED TOTAL AGENCY EXPENSES SUPPLEMENTARY SHEET

Form 5S provides a detail calculation of the amounts to be reported in each Control Account on Form 5, but is not a mandatory form.

EXCEPTION: Any for profit entity including an allowable profit in their funding request **MUST** include the allowable profit calculation found on the last page of Form 5S.

Column A - See detailed chart of accounts in Section 4 of these guidelines for account definitions.

Column B - Fill in the 2005 Gross Budget of the entire Agency by Control Account as adopted by the agency's Board of Directors or owners of the agency.

Column C - Enter the total 2006 projected annual cost of the entire Agency by Control Account as approved by the agency's Board of Directors or owners of the agency. Column C must equal the sum of the entries in Columns D through E.

Column(s) D - Enter the 2006 projected annual cost of each individual program applied for by Control Account. Include a separate Column E for each program applied for in Disabilities Services Division, Economic Support Division and Delinquency and Court Services Division. These entries must agree to the amounts reported in each individual Form 3. If the Agency is applying for more than four (4) programs, use additional copies of Form 5 to report **all** programs applied for in **all** DHHS Divisions **individually**.

Column E - Enter the 2006 projected annual indirect cost to be allocated to programs utilizing a cost allocation plan by Control Account.

DIRECT

EXPENSES - Bring forward “Total Expenses” from Form 5, column E for each program in Column D.

NET

ASSETS - Net Assets are those assets directly related to and used specifically by each program Column D. Assets used by the entity in general are reported in Column E.

Total Fixed Assets. Include asset cost (January 1, and December 31). Be sure to include the cost of any anticipated Fixed Assets purchases during the year.

Accumulated Depreciation. Include accumulated depreciation on those assets included above at January 1 and December 31. Be sure to include the current year anticipated depreciation in calculating the ending accumulated depreciation.

Directly Associated Debt. Deduct the loan balances January 1 and December 31 of any debt directly associated with the purchase and acquisition of specific assets. Do not include general debt obligations.

ALLOCATED

AVERAGE NET

ASSETS - Average net assets of fixed assets used by the entity in general (Column E) are normally allocated on the basis of the relation of the total program expenses to the entity’s total expenses. If a basis other than relative direct expenses is used to allocate the average net assets of those assets used by the entity as a whole is used, provide a detailed narrative description of the basis as an attachment to Form 5S.

FORM 5 – TOTAL AGENCY ANTICIPATED EXPENSES

Item # 23

FORM 5 YEAR 2006 TOTAL AGENCY ANTICIPATED EXPENSES

AGENCY NAME: _____

Control Acct. No.	(A) Expenditure Description	(B) 2004 Actual	(C) 2005 Gross Budget	(D) 2006 Gross Budget	(E) (program) Gross Budget	(E) (program) Gross Budget	(E) (program) Gross Budget	(F) Indirect Costs Gross Budget*	(G) Other Contracts Programs & Functions**
7000	Salaries								
7100	Employee Health & Retirement Benefits								
7200	Payroll Taxes								
8000	Professional Fees								
8100	Supplies								
8200	Telephone								
8300	Postage and Shipping								
8400	Occupancy								
8500	Rental, Maintenance & Depreciation of Equipment								
8600	Printing and Publications								
8700	Travel								
8800	Conferences, Conventions, Meetings								
8900	Specific Assistance to Individuals								
9000	Membership Dues								
9100	Awards and Grants								
9200	Allocated Costs (From Indirect Cost Allocation Plan, if applicable) *								
9300	Client Transportation								
9400	Miscellaneous								
9500	Depreciation or Amortization								
9600	Allocations to Agencies, Payments to affiliated Organizations								
	TOTAL EXPENSES								
	PROFIT FACTOR								
	TOTAL EXPENSES INCLUDING PROFIT								
	TOTAL NON-DHHS CONTRACT REV BROUGHT FWD								
	TOTAL DHHS REQUEST								

Rev 6/05 Date Submitted: _____

* Control Account Number 9200, Allocated Costs, column F, should be entered as a negative number in order for column D to cross-foot to zero.

** Use Other Contracts Programs & Functions, column G for all non-Milwaukee County programs or functions

FORM 5A YEAR 2006 TOTAL AGENCY ANTICIPATED REVENUE

AGENCY NAME: _____

Control Acct. No.	(A) Revenue	(B) 2004 Actual	(C) 2005 Revenue Budget	(D) 2006 Revenue Budget	(E) (program) Revenue Budget	(E) (program) Revenue Budget	(E) (program) Revenue Budget	(E) (program) Revenue Budget	(F) Indirect Costs Revenue Budget	(G) Other Contracts Prog. & Func. Revenue Budget*
4000	Contributions and Donations									
4100	Contributions to Building Fund									
4200	Special Events									
4300	Legacies and Bequests									
4500	Collected through Local Member Units									
4600	Contributed by Associated Organizations									
4700	Allocated by Federated Fund Raising Organizations									
4800	Allocated by Unassociated and Non-Federated Fund Raising Organizations									
5100	Other Government Purchase of Service (DO NOT INCLUDE ANY REQUESTS FROM DHHS)									
5200	Grants from Other Governmental Agencies (DO NOT INCLUDE ANY REQUESTS FROM DHHS)									
5300	Revenues from HMO and PPO									
6000	Membership Dues									
6100	Assessments and Dues-Local Member Units									
6200	Program Service Fees-Other									
6300	Intra-Agency Sales of Supplies and Services									
6400	Revenues from Disposal of Assets									
6500	Investment Income									
6600	Gains (and Losses) on Investment Transactions									
6900	Miscellaneous Revenue									
	TOTAL NON-DHHS CONTRACT REVENUE									
	DHHS CONTRACT REQUEST									
	TOTAL REVENUE									

Date Submitted: _____

* Use Other Contracts Programs & Functions, column G for all non-Milwaukee County programs or functions

FORM 55 ANTICIPATED TOTAL AGENCY EXPENSES SUPPLEMENTARY SHEET

AGENCY NAME: _____

Control Acct. No.	Sub-Account Number	(A) Account Description	(B) 2005 Gross Budget	(C) 2006 Gross Budget	(D) (program) Gross Budget	(D) (program) Gross Budget	(E) Indirect Costs Gross Budget***	(F) Other Contracts Programs & Functions****
7000	7001	Executive Salaries						
	7002	Professional Salaries						
	7003	Clerical Staff Salaries						
	7004	Technical Salaries						
	7005	Maintenance Employee's Wages						
	7006	Temporary Clerical Help						
	7007	Student Stipends						
	7008	Other Staff Salaries (Unclassified)						

CONTROL ACCOUNT NO. 7000 SUB TOTAL *

7100	7101	Accident Insurance Premiums						
	7102	Life Insurance Premiums						
	7103	Medical & Hospital Plan Premiums						
	7104	Pension or Retirement Plan Premiums						
	7105	Supp. Payments to Pensioned Employees						
	7106	Payments to Annuitant						
	7107	Employment Termination Expenses						
	7108	Employee Tuition Reimburse. Plan						

CONTROL ACCOUNT NO. 7100 SUB TOTAL *

7200	7201	FICA Payments (Employer's Share)						
	7202	Unemployment Insurance						
	7203	Workmen's Compensation Insurance						
	7204	Disability Insurance Premiums						

CONTROL ACCOUNT NO. 7200 SUB TOTAL *

8000**	8001	Medical & Dental Fees						
	8002	Psychological Fees						
	8003	Legal Fees						
	8004	Rehabilitation & Education Fees						
	8005	Development & Public Relations Fees						
	8006	Brokerage, Commission, Collection Fee						
	8007	Employment Fees						
	8008	Audit Fees						
	8009	Electronic Data Processing Service Fee						
	8010	Other Contract Payments to Consultant						
	8011	Talent Fees						
	8012	Other Purchased Services						

CONTROL ACCOUNT NO. 8000 SUB TOTAL *

* Must be the same dollar amount as shown on Form 5

** Attach a copy of the memorandum of agreement between the agency and the professional when using Control Account No. 8000, Sub-Account Nos. 8001 through 8012

*** Control Account Number 9200, Allocated Costs, column E, should be entered as a negative number in order for column C to cross-foot to zero.

**** Use Other Contracts Programs & Functions, column F for all non-Milwaukee County programs or functions

FORM 55 ANTICIPATED TOTAL AGENCY EXPENSES SUPPLEMENTARY SHEET

AGENCY NAME: _____

Control Acct. No.	Sub-Account Number	(A) Account Description	(B) 2005 Gross Budget	(C) 2006 Gross Budget	(D) (program) Gross Budget	(D) (program) Gross Budget	(E) Indirect Costs Gross Budget	(F) Unallowable Costs Gross Budget
8100	8101	Medicine & Drugs (Clinic Use Only)						
	8102	Prosthetic Appliances (Clinic Use Only)						
	8103	Recreational, Voc. & Craft Supplies						
	8104	Food & Beverages						
	8105	Laundry, Linen, & Housekeeping Supplies.						
	8106	Office Supplies-Stationery, Typing						
	8107	Paper, Ink, Printing, Duplicating						
	8108	New Goods Purchased						
	8109	Raw Materials (Manufacturing) Purchased.						
	8110	Manufacturing Supplies						

CONTROL ACCOUNT NO. 8100 SUB TOTAL*

8200	8201	Telephone Expense						
	8202	Telegraph Expense						

CONTROL ACCOUNT NO. 8200 SUB TOTAL*

8300	8301	Postage and Parcel Post						
	8302	Freight						
	8303	Messenger & Delivery Service						

CONTROL ACCOUNT NO. 8300 SUB TOTAL *

8400	8401	Office Rent						
	8402	Other Bldg. & Parking Lot Rent						
	8403	Bldg. & Bldg. Eq. Ins. (Gen. & Liability)						
	8404	Mortgage Interest						
	8405	Electricity						
	8406	Gas						
	8407	Heating Oil						
	8408	Water & Sewer						
	8409	Janitorial/Maintenance/Repairs Purchased						
	8410	Real Estate Taxes						
	8411	Personal Property Taxes						
	8412	Licenses & Permits-Occupancy Related						
	8413	Bldg. & Grounds Maintenance Supplies						
	8414	Miscellaneous Occupancy Costs						
	8415	Amortization/Leasehold Improvements						
	8416	Depreciation - Buildings						

CONTROL ACCOUNT NO. 8400 SUB TOTAL*

8500	8501	Equipment rental expenses						
	8502	Equipment Maintenance expenses						
	8503	Equipment - Depreciation						
	8504	Equipment - Interest Expense						

CONTROL ACCOUNT NO. 8500 SUB TOTAL *

FORM 55 ANTICIPATED TOTAL AGENCY EXPENSES SUPPLEMENTARY SHEET

Item # 32

AGENCY NAME: _____

Control Acct. No.	Sub-Account Number	(A) Account Description	(B) 2005 Gross Budget	(C) 2006 Gross Budget	(D) (program) Gross Budget	(D) (program) Gross Budget	(E) Indirect Costs Gross Budget	(F) Unallowable Costs Gross Budget
8600	8601	Printing						
	8602	Artwork						
	8603	Photography						
	8604	Recording						
	8605	Films						
	8606	Subscriptions-Periodicals/Publication						
	8607	Purchase of Publications						
	8608	Media Use Charges-Public Information						

CONTROL ACCOUNT NO. 8600 SUB TOTAL*

8700	8701	Local Bus & Taxicab Fares						
	8702	Gas & Oil - Company Vehicles						
	8703	Repairs - Company Vehicles						
	8704	Insurance - Company Vehicles						
	8705	Licenses & Permits-Company Vehicles						
	8706	Leasing Costs - Company Vehicles						
	8707	Auto Allowance(Employees/Volunteers)						
	8708	Tires - Company Vehicles						
	8709	Hotel, Meals, & Incidental Expenses						
	8710	Depreciation - Automotive Equipment						

CONTROL ACCOUNT NO. 8700 SUB TOTAL*

8800	8801	Meeting Space & Equipment Rental						
	8802	Meeting Supplies (Notices,Badges,etc.)						
	8803	Food & Beverages Costs(Mtg. Particlp.)						
	8804	Speaker's Honoraria & Expenses						
	8805	Registration Fees						

CONTROL ACCOUNT NO. 8800 SUB TOTAL*

8900	8901	Medical Fees						
	8902	Dental Fees						
	8903	Medicines						
	8904	Children's Board						
	8905	Homemaker Service						
	8906	Food Service						
	8907	Shelter Service						
	8908	Clothing Service						
	8910	Recreation Service						
	8911	Wage Supplements						
	8912	Prosthetic Appliances						
	8913	Hospital Fees						
	8914	Testing Fees						
	8915	Materials - Crafts, Vocation, etc.						

CONTROL ACCOUNT NO. 8900 SUB TOTAL*

FORM 55 ANTICIPATED TOTAL AGENCY EXPENSES SUPPLEMENTARY SHEET

AGENCY NAME: _____

Control Acct. No.	Sub-Account Number	(A) Account Description	(B) 2005 Gross Budget	(C) 2006 Gross Budget	(D) (program) Gross Budget	(D) (program) Gross Budget	(D) (program) Gross Budget	(E) Indirect Costs Gross Budget	(F) Unallowable Costs Gross Budget
9000	9001	Individual Dues							
	9002	Organizational Dues							
CONTROL ACCOUNT NO. 9000 SUB TOTAL *									
9100	9101	Grants to Research Institutions							
	9102	Graduate Fellowships							
	9103	Trainee Scholarships							
	9104	Other Scholarships/Tuition Payments							
	9105	Allowance for Travel Under Grant							
	9106	Allowance for Equipment Under Grant							
	9107	Lump Sum Camperships							
	9108	Contribution/Grants to Hum. Serv. Org.							
	9109-50	Awards & Grants to Indiv./Other Org.							
	9151-99	Awards & Grants to Affiliate Organizat.							
CONTROL ACCOUNT NO. 9100 SUB TOTAL *									
9200	9201	Administrative Costs (Indirect Costs)							
	9202	Transportation							
CONTROL ACCOUNT NO. 9200 SUB TOTAL *									
9300	9301	Local Bus & Taxicab Fares							
	9302	Gas & Oil - Company Vehicles							
	9303	Repairs - Company Vehicles							
	9304	Insurance - Company Vehicles							
	9305	Licenses & Permits-Company Vehicles							
	9306	Leasing Costs - Company Vehicles							
	9307	Tires - Company Vehicles							
	9308	Depreciation - Auto Equipment							
CONTROL ACCOUNT NO. 9300 SUB TOTAL *									
9400	9401	Employee Malpractice Insurance							
	9402	Employee Bonding Insurance							
	9403	Other							
CONTROL ACCOUNT NO. 9400 SUB TOTAL *									
9500	9501-9504	Depreciation or Amortization							
See Accounts Related to the Statement of Expenses in the GUIDELINES									
9600	9601-9690	Allocations to Agencies,							
	9691	Payments to Affiliated Organizations							
CONTROL ACCOUNT NO. 9600 SUB TOTAL *									
GRAND TOTAL *****									

Rev. 5/05

Date Submitted: _____

*****Must be the same dollar amount as shown on Form 3, on the line titled "TOTAL EXPENSES"

FORM 55 ANTICIPATED TOTAL AGENCY EXPENSES SUPPLEMENTARY SHEET

Item # 32

AGENCY NAME: _____

Control Acct. No.	Sub-Account Number	(A) Account Description	(B) 2005 Gross Budget	(C) 2006 Gross Budget	(D) _____ (program) Gross Budget	(D) _____ (program) Gross Budget	(D) _____ (program) Gross Budget	(E) Indirect Costs Gross Budget	(F) Unallowable Costs Gross Budget
Profit Factor Calculation:									
Direct Expenses									
[1]		7.5% of Direct Expenses	N/A					N/A	N/A
Net Assets - Beginning of Year									
Total Fixed Assets									
Deduct Accumulated Depreciation									
Net Fixed Assets									
Directly Associated Debt									
Net Assets - Beginning of Year									
[2a]									
Net Assets - End of Year									
Total Fixed Assets									
Deduct Accumulated Depreciation									
Net Fixed Assets									
Directly Associated Debt									
Net Assets - End of Year									
[2b]									
[2c]		Average Net Assets - directly associated ([2a] + [2b] / 2)	N/A						
Allocated Average net Assets (allocated on basis of direct expenses)									
Total Average Net Assets									
[2]		15% of Total Average Net Assets	N/A	N/A				N/A	N/A
[3]		Total Tentative Profit Factor	N/A	N/A				N/A	N/A
[4]		10% of Direct Expenses	N/A	N/A				N/A	N/A
Allowable Profit Factor (lesser of [3] or [4])									
			N/A	N/A				N/A	N/A

Date Submitted: _____